New Hampshire

GROWTH HORMONE MEDICATIONS

NH Medicaid Prior Authorization

Request Form

First Health Services Corporation
A Coventry Health Care Company

Fax: 1-888-603-7696 Phone: 1-866-675-7755

Date of Medication Request: ___ ___ /___ ___ /___ ___ _

Section I: Patient Information and Medication Requested:

Name: (Last, First) _____ NH Medicaid Number:___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___

Date of Birth: ___ ___ /___ ___ /___ ___ ___ ___ Gender: ☐ Male ☐ Female

Drug Name:_____ Strength:_____

Dosing Directions:_____ Length of Therapy:_____

Section II: Clinical History:

1. Is the prescriber an endocrinologist, nephrologist, or has one been consulted on this case? ☐ Yes ☐ No
2. What is the patient's age?_____
3. What is the patient's height?_____
4. Is patient a newborn with hypoglycemia and a diagnosis of hypopituitarism or panhypopituitarism? ☐ Yes ☐ No
5. What is the diagnosis/condition being treated with this medication? (or check all that apply)_____

☐ Growth hormone deficiency (pediatric) ☐ Growth hormone deficiency (adult onset) ☐ Prader-Willi Syndrome
☐ Turner Syndrome ☐ Renal Insufficiency ☐ Chronic Renal Insufficiency
☐ Short Bowel Syndrome ☐ HIV wasting or cachexia ☐ Small for Gestational Age

LAB/TEST RESULTS (please provide all lab/test results that apply to the condition being treated)

1. Are the epiphyses open or closed?_____
2. What are the results of bone age studies?_____
3. Is patient's height more that 2 SD below average for population mean height for age and sex? ☐ Yes ☐ No
4. Is the patient's height velocity measured over one year to be 1 SD below the mean for chronological age? ☐ Yes ☐ No
5. For children over two years of age, has there been a decrease in height SD of more than 0.5 over one year? ☐ Yes ☐ No
6. What is the patient's growth hormone response to a provocative stimulation test? (two are required: insulin, levodopa, L-Arginine, clonidine, or glucagon) _____ng/ml
7. In adult onset growth hormone deficiency, have the following hormonal deficiencies been ruled out? (check all that apply)
   ☐ Thyroid ☐ Cortisol ☐ Sex Steroids

MISCELLANEOUS REQUIRED INFO (please provide if applicable)

1. If being prescribed for AIDS Wasting or cachexia, has the patient had documented failure, intolerance, or contraindication to appetite stimulants and/or other anabolic agents (both Megace and Marinol)? ☐ Yes ☐ No
2. If this is a renewal, has patient had a positive response to therapy? ☐ Yes ☐ No
3. What are the parental heights? _____ What is the growth velocity per year? _____

Please provide information to support a positive response to therapy (i.e. improvements in height, weight, body composition, increased growth velocity, response on growth curve chart). Please provide quantitative improvements._____

_____

_____

Please provide any additional information that would help in the decision-making process. If additional space is needed, please use a separate sheet. _____

Section III: Prescriber Information:

Print Name: _____ DEA Number: ___ ___ ___ ___ ___ ___ ___ ___ ___

Phone Number: (___ ___ ___) ___ ___ ___ - ___ ___ ___ ___ Fax Number: (___ ___ ___) ___ ___ ___ - ___ ___ ___ ___

I certify that the information provided is accurate and complete to the best of my knowledge and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

_____

Signature of Prescribing Provider

Revised 02/25/08